

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013236</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTH WOODS VILLAGE AT EDISON LAKES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1409 E DAY ROAD MISHAWAKA, IN 46545</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey Dates: May 4 and 6, 2015</p> <p>Facility number: 013236 Provider number: 013236 Aim number: N/A</p> <p>Census bed type: Residential: 47 Total: 47</p> <p>Census payor type: Other: 47 Total: 47</p> <p>Sample: 5</p> <p>North Woods Village at Edison Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE